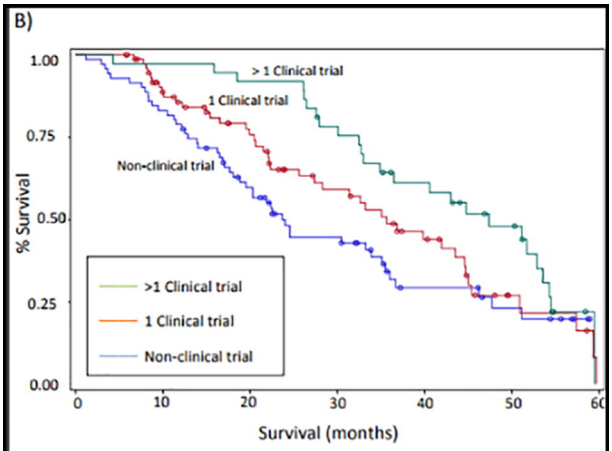

	Time (months)		
Survival distribution	>1 Clinical trial	1 Clinical trial	Non-clinical trial
75%	54.47	50.86	47.70
50%	47.37	35.61	23.65
25%	32.43	20.47	12.85
Wilcoxon: p=0.0008; Log-Rank: p=0.0281			

Fig. 1. 5-year survival distribution based on clinical trial participation (A) and number of clinical trials participated in (B). Clinical trial participants had a significantly improved 5-year survival distribution compared to those that did not participate (40.54 vs. 23.65 months; Wilcoxon: $P = 0.0011$; Log-Rank: $P = 0.0211$). Additionally, patients that participated in >1 clinical trial had significantly improved 5-year survival distribution compared to those that participated in a single clinical trial (47.37 vs. 35.61 months; Wilcoxon: $P = 0.0008$; Log-Rank: $P = 0.0281$).

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449 - Poster Session

Variation in adjuvant therapy for stage II serous uterine cancer in the United States and its impact on survival outcome

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Objective: We sought to determine the patterns of adjuvant treatment received by women with stage II serous uterine cancer in the United States and to evaluate the impact of these variations on overall survival.

Method: The Medicare and Surveillance, Epidemiology, and End Results (SEER) database was used to identify women 65 years or older diagnosed with stage II uterine cancer from 1999 to 2011 who underwent primary surgical management via hysterectomy. Exclusion criteria included more than 1 primary cancer, history of end-stage renal disease/dialysis, and lack of activity in Medicare 1 year pre- and postdiagnosis. Adjuvant therapy including radiation (RT), chemotherapy, and sequence were collected. Demographics, surgical staging, pathology, and survival outcomes were collected. Descriptive statistics, Kaplan-Meier curves, and Cox models were used for analyses.

Results: A large portion of women with stage II serous uterine carcinoma ($n = 106$) received no adjuvant therapy 37% ($n = 39$). A large portion of the remaining women received RT alone (26%, $n = 28$) or chemotherapy alone (24%, $n = 25$). For the remaining patients, therapy included 3.8% ($n = 4$) concurrent chemotherapy and RT; 0.9% ($n = 1$) RT followed by chemotherapy; 6.6% ($n = 7$) chemotherapy followed by RT; and 1.9% ($n = 2$) sandwich chemotherapy-RT-chemotherapy. Factors associated with not receiving adjuvant treatment included old age (64% untreated age older than 80 years versus 30% age 70–79 years and 29% age 40–69 years, $P < 0.001$), higher income (50% untreated if more than $75,000 compared to 37% if $55,000–$75,000, 24% if $40,000–$55,000, and 39% if less than $40,000), and region (53% untreated in the West compared to 32% Northeast, 21% Midwest, and 31% South). Marital status, race, Charlson comorbidity score, and lymphadenectomy were not associated with receiving adjuvant treatment. There was no statistical difference in OS between the adjuvant treatment variations including the lack of adjuvant treatment ($P = 0.44$). See Fig. 1.

Conclusion: Nearly 37% of women with stage II serous uterine cancer receive no adjuvant treatment. Factors associated with lack of receipt of adjuvant treatment included older age, higher income, and region of care. Despite these variations, there was no impact on OS. Further investigation into the use of adjuvant treatment in this population is warranted.

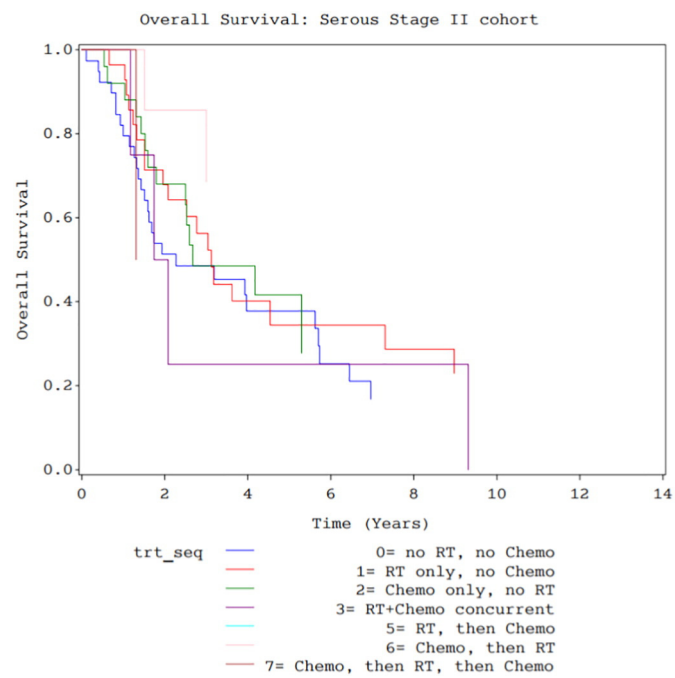

Fig. 1.

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450 - Poster Session

Cervical cancer screening and goals for transition in female-to-male transgender individuals at a community health center in the southern United States

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Objective: To evaluate current cervical cancer screening practices for female-to-male (FtM) transgender individuals at a community health clinic in the southern United States.

Method: A retrospective chart review of demographic characteristics and treatment of transgender men at a single community health clinic. Patients with an ICD-10 diagnosis code for Gender Identity Disorder (GID) and female sex assigned at birth from 2013 to 2017 were included.

Results: Of the 145 individuals with codes for GID, 80 (55.2%) were classified as female and 65 (44.8%) as male. Seventy-one participants

had female sex assigned at birth (i.e., biologically female). Of those, 66.2% ($n = 47$) were Caucasian and 18.3% ($n = 13$) African-American; median age was 24 years (IQR 21.5–27 years); and 33.8% ($n = 24$) had health insurance. Of 64 participants eligible for cervical cancer screening per American Society of Colposcopy and Cervical Pathology (ASCCP) guidelines, 52.4% ($n = 33$) were up-to-date; 22.2% ($n = 14$) had received past screening but were delinquent; 6.3% ($n = 4$) were never screened; and data were insufficient for 19.0% ($n = 12$). Median age of those never screened was 26 (range 22–27) years; median age for those up-to-date was 23 (range 18–38) years. Median age of coitarche was 17 years (IQR 15–18 years); and 25.4% ($n = 18$) had more than 5 lifetime partners. Participants' sexual partners were exclusively female (31.0%), male (0.3%), or both male and female (49.3%). Two had transgender partners. All participants were pursuing gender-affirming hormone therapy, with primary goals of male pattern hair growth (43.7%) and body habitus (47.9%). Three had previously procured testosterone illicitly. The majority were not planning surgery to remove their breasts, cervix, or uterus (Table 1). While there was interest in amenorrhea (21.1%) and low desire for future fertility (8.4%), only 4 were considering future hysterectomy. One already underwent hysterectomy for an alternative indication. Five participants had mastectomies with 10 considering mastectomy in the future.

Conclusion: Compliance with ASCCP guidelines for cervical cancer screening by transgender men in our community is below the national average for women. Efforts to more accurately document sex assignment at birth, gender identity, and present anatomy should be pursued to improve care in this unique population.

Table 1
Goals and plans for gender affirmation ($n = 71$)

Mastectomy *n* (%)	
Completed	5 (7.0%)
Desires	10 (14.1%)
Hysterectomy *n* (%)	
Completed	1 (1.4%)
Desires	4 (5.6%)
Desires phalloplasty *n* (%)	1 (1.4%)
Goals of therapy *n* (%)	
Male pattern hair growth	31 (43.7%)
Male muscle/fat distribution	34 (47.9%)
Absence of menses	15 (21.1%)
Male voice	14 (19.7%)
Increased libido	1 (1.4%)
Outer appearance consistent with self image	7 (9.9%)
Desires future fertility *n* (%)	
Yes	2 (2.8%)
Maybe	4 (5.6%)
No, childbearing complete	4 (5.6%)
No desire for biological children	46 (64.8%)
Did not answer	15 (21.1%)

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451 - Poster Session

Patient perceived attitudes and practice patterns regarding hormone replacement therapy (HRT) after risk reducing gynecologic surgery for Lynch syndrome

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Objective: To describe the current patient-perceived attitudes and practice patterns regarding hormone replacement therapy (HRT) in patients who undergo risk-reducing surgery for Lynch syndrome (LS). Secondary outcomes were patient-reported changes in quality of life and sexual function after risk-reducing surgery.

Method: Women with a diagnosis of LS were contacted via social media and asked to participate in an institutional review board-approved, web-based, 55-question survey regarding risk-reducing gynecologic surgery and HRT. Women were contacted by posting the survey on social media outlets specific to LS.

Results: A total of 91 women with mean age 46 years, who self-identified as being diagnosed with LS, responded to the survey. The majority were college-educated (56%) non-Hispanic white women (85.6%) with private insurance (76.7%) residing in the United States (91.1%), and were diagnosed with LS between 30 and 50 years of age (69.3%). Of the 91 respondents, 80.5% reported being referred to a genetic counselor to discuss the diagnosis of LS. Sixty-one respondents (75%) reported having undergone a risk-reducing bilateral salpingo-oophorectomy (BSO), 80% of whom were younger than 50 years at the time of surgery. Of the respondents, 66% reported that HRT was not discussed following risk-reducing surgery. Patient-reported reasons for not taking HRT included concern for increased risk of blood clots (7%), cancer (28%), HRT not being natural (2%), and inability to afford (3%). After BSO, women reported decreased sexual activity (67%), sleep (21%), mood (20%), general well-being (15%), ability to exercise (18%), and increased hot flashes (30%). The percentage of women who reported that they were not counseled about the risks of BSO on their quality of life was 30.8%. When analysis was restricted to women younger than 50 years without known contraindications to HRT (smoking, migraines, endometrial or ovarian cancer, thromboembolic disease, $n = 48$), 19% reported that HRT was not discussed and 40% that they were not offered HRT.

Conclusion: A significant number of surveyed women who received risk-reducing BSO for LS were not offered HRT despite the well-known effects of surgical menopause on quality of life. The perceived reasons patients do not choose to receive HRT are modifiable with both patient and provider education.

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452 - Poster Session

Joint exposure to smoking, excessive weight, and physical inactivity affects survival of ovarian cancer patients: Evidence from the Ovarian Cancer Association Consortium

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Objective: To evaluate the combined effect of unfavorable lifestyle factors, including smoking, obesity, and physical inactivity, on ovarian cancer prognosis.

Method: Using pooled data from 13 studies participating in the Ovarian Cancer Association Consortium, we examined the association between exposure to smoking, excessive weight, and physical inactivity and overall survival (OS) and progression-free survival (PFS) among women diagnosed with invasive epithelial ovarian carcinoma. Using age- and stage-adjusted Cox proportional hazards regression models, we estimated hazard ratios (HRs) and 95% confidence intervals (CIs) associated with joint exposure to these factors.

Results: Combined exposure to current smoking, overweight/obesity, and physical inactivity prior to diagnosis ($n = 159$) was associated with a statistically significant increased risk of mortality